PATIENT INFORMATION Pediatric Orthopaedic Associates

Please Fill Out Completely:

Patient's Name: _____ (First / M.I. / Last) SSN: _____

Date of Birth: _____ Age: _____ Sex: [ ]M [ ]F (M,F)

Patient's Address: _____ (Address / City / State / Zip)

Home Phone (Primary): _____ Phone (Secondary): _____

Mother: _____ Father: _____

SSN: _____ DOB: _____ SSN: _____ DOB: _____

Address (if different): _____ Address (if different): _____

Home Phone: _____ Home Phone: _____

Work Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

Email: _____ Email: _____

Emergency Contact Name: _____ Emergency Contact Relationship: _____

Home Phone: _____ Work Phone: _____ Other Phone: _____

Referred By: _____ Phone: _____

PCP: _____ Phone: _____

Date of Accident or Injury: _____ Details: _____

Primary Insurance Information

Primary Insurance Co.: _____ Patient ID: _____

Policyholder: _____ Sex: ☐ Male ☐ Female

Group Number: _____ Group Name: _____

Relationship to patient: _____

Policyholder SSN: _____ Policyholder Date of Birth: _____

Secondary Insurance Information

Secondary Insurance (_____ Sex: ☐ Male ☐ Female

Policyholder: _____ Patient ID: _____

Group Number: _____ Group Name: _____

Relationship to patient: _____

Policyholder SSN: _____ Policyholder Date of Birth: _____

List Any Persons to Whom You Will Allow Access Of Your Medical Records

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

I understand terms are for services rendered. (If these terms create a problem, please see the business office about making other arrangements before you are examined.) I will be responsible for all charges incurred by me. Should collection proceedings become necessary, I agree to pay all costs of collection including a reasonable attorney's fee and waive all rights to claim personal property exempt under the laws of the state of Georgia. I hereby assign to and authorized payment directly to Pediatric Orthopaedic Associates, P.C. All benefits payable under the terms of any insurance policy listed above if insurance is filed by the office. I realize the insurance benefits may not pay all of the bill and agree to pay the difference or the entire bill, if necessary. I authorize the release of any medical information necessary to process my insurance claims or to continue my medical care. I acknowledge that I have been provided access to notice of privacy practices of Pediatric Orthopaedic Associates, P.C.

Signature: _____ Date _____

Responsible Party